KAMALA D. HARRIS
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
STERLING A. SMITH
Deputy Attorney General
State Bar No. 84287
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-0378
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SUSAN C. HUNTER** **aka SUSAN COE PICKEL** 6006 Scalybark Rd. Durham, NC 27712 **Registered Nurse License No. 321551** **Public Health Nurse Certificate No. 31418** Respondent.	Case No. 2013-691 **ACCUSATION**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about August 31, 1980, the Board issued Registered Nurse License Number 321551 to Susan Coe Hunter, also known as Susan Coe Pickel ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2014, unless renewed.

Public Health Nurse Certificate

3. On or about July 3, 1981, the Board issued Public Health Nurse Certificate Number PHN 31418 to Respondent. The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2014, unless renewed.

JURISDICTION

4. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

6. Code section 2761(a) states, in pertinent part, that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

7. Code section 2762 states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. "Morphine," is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(L).

11. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(j).

12. "Percocet," a brand of oxycodone and acetaminophen, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

13. "Lorazepam" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16).

14. "Versed," a brand of midazolam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(21).

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries in Hospital or Patient Records)

15. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that between August 3, 2007, and August 10, 2008, while a registered nurse in the Surgical Intensive Care Unit at the Department of Veterans Affairs Medical Center, located in Durham, North Carolina, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient 26:

a. On or about August 3, 2007, at 2307 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of 0.5 mg. of

Hydromorphone at 2311 hours, but failed to account for the remaining 1.5 mg. of Hydromorphone in any hospital or patient record.

Patient 27:

b. On or about August 11, 2007, at 2214 hours, Respondent signed out one (1) 2 mg. injectable of Lorazepam. Respondent charted the administration of 0.5 mg. of Lorazepam at 2351 hours, but failed to account for the remaining 1.5 mg. of Lorazepam in any hospital or patient record. In addition, Respondent did not administer the Lorazepam to the patient for more than one hour after signing it out.

Patient 28:

c. On or about August 15, 2007, at 0033 hours, Respondent signed out one (1) 5 mg. tablet of Oxycodone. Respondent charted the administration of the Oxycodone at 0037 hours. However, the administration of Oxycodone was inconsistent with physician's orders calling for the administration of Oxycodone every six (6) hours, in that the patient had received one 5 mg. tablet of Oxycodone on August 14, 2007, at 2019 hours.

Patient 32:

d. On or about August 26, 2007, at 1948 hours, Respondent signed out one (1) 2 mg. injectable of Morphine. Respondent charted the administration of the Morphine at 2003 hours. However, the administration of the medication was inconsistent with physician's orders, which called for the administration of Morphine on August 25, 2007, at 2052 hours, more than 22 hours earlier.

Patient 33:

e. On or about October 21, 2007, at 2221 hours, Respondent signed out one (1) 5 mg. tablet of Oxycodone, but failed to account for the disposition of the Oxycodone in any hospital or patient record.

///

///

///

///

Patient 35:

f. On or about September 23, 2007, at 2023 hours, Respondent signed out one (1) 5 mg. tablet of Oxycodone for administration. Respondent charted the administration of the Oxycodone at 2126 hours. The administration of the Oxycodone was inconsistent with physician's orders, that called for the administration of the medication every three (3) hours, in that the previous dose was administered at 2003 hours.

Patient 36:

g. On or about September 22, 2007, at 0151 hours, Respondent signed out one (1) 2 mg. injectable of Lorazepam for administration. Respondent charted the administration of one (1) mg. of Lorazepam at 0215 hours, but failed to account for the remaining one (1) mg. of Lorazepam in any hospital or patient record.

Patient 38:

h. On or about November 10, 2007, Respondent signed out Morphine for a Patient Control Analgesic ("PCA"). Respondent failed to properly document the administration of the medication.

Patient 39:

i. On or about September 16, 2007, Respondent signed out 1000 mcg. of Fentanyl for a PCA, but failed to properly document the administration of the medication on the patient's chart.

Patient 40:

j. On or about September 1, 2007, at 0022 hours, Respondent signed out one 10 mg. cassette of Dilaudid for a PCA. However, Respondent charted that she started the infusing of the medication on August 31, 2007, at 2245 hours, over an hour prior to signing out the medication.

Patient 42:

k. On or about December 30, 2007, at 2039 hours, Respondent signed out two (2) tablets of Percocet for administration. Respondent charted the administration of the Percocet at 2051 hours. The administration of the Percocet is inconsistent with physician's orders that called for the administration of the medication every four (4) hours, in that the previous dose was administered at 1741 hours.

Patient 43:

l. On or about September 1, 2007, at 0151 hours Respondent signed out one 10 mg. cassette of Dilaudid for a PCA, but failed to account for the Dilaudid in any hospital or patient record.

Patient 44:

m. On or about September 29, 2007, Respondent failed to administer the correct dosage of Fentanyl and Bupivicaine, in that Respondent administered 13 cc's per hour when the physician's order called for 6 cc's per hour.

Patient 45:

n. On or about December 1, 2007, at 0341 hours, Respondent signed out 5 mg. of Oxycodone for administration. Respondent charted the administration of the Oxycodone at 0349 hours. However, the administration of Oxycodone was inconsistent with physician's orders, which called for the administration of Tylenol prior to the administration of Oxycodone.

Patient 46:

o. On or about December 7, 2007, at 2334 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 50 mcg. of Fentanyl at 2342 hours. Respondent failed to account for the remaining 50 mcg. of Fentanyl in any hospital or patient record.

p. On or about December 8, 2007, at 0626 hours, Respondent charted the administration of 50 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

Patient 47:

q. On or about December 9, 2007, at 0222 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 50 mcg. of Fentanyl at 0228 hours. Respondent failed to account for the remaining 50 mcg. of Fentanyl in any hospital or patient record.

///

///

r. On or about December 9, 2007, at 0700 hours, Respondent charted the administration of 50 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

Patient 48:

s. On or about December 9, 2007, at 2053 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 50 mcg. of Fentanyl at 2101 hours. Respondent failed to account for the remaining 50 mcg. of Fentanyl in any hospital or patient record.

t. On or about December 10, 2007, at 00201 hours, Respondent charted the administration of 50 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

Patient 49:

u. On or about December 10, 2007, at 0443 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 50 mcg. of Fentanyl at 0449 hours. Respondent failed to account for the remaining 50 mcg. of Fentanyl in any hospital or patient record.

Patient 50:

v. On or about December 13, 2007, at 0702 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 50 mcg. of Fentanyl at 0708 hours. Respondent failed to account for the remaining 50 mcg. of Fentanyl in any hospital or patient record.

Patient 51:

w. On or about December 14, 2007, at 2042 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl at 2048 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

x. On or about December 14, 2007, at 2324 hours, Respondent charted the administration of 25 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

y. On or about December 15, 2007, at 0206 hours, Respondent charted the administration of 25 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

Patient 52:

z. On or about December 15, 2007, at 2131 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl at 2137 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

aa. On or about December 16, 2007, at 0115 hours, Respondent charted the administration of 25 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

bb. On or about December 16, 2007, at 0640 hours, Respondent charted the administration of 25 mcg. of Fentanyl. However, there was no corresponding withdrawal of Fentanyl in or about that time frame.

Patient 53:

cc. On or about December 15, 2007, at 0649 hours, Respondent signed out one (1) tablet of Vicodin for administration. Respondent charted the administration of the Vicodin at 0655 hours. The administration of the Vicodin was inconsistent with physician's orders calling for the administration of that medication every four (4) hours, in that the previous dose was administered at 0349 hours.

Patient 54:

dd. On or about January 4, 2008, at 2045 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl on January 5, 2008, at 0035 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

///

///

///

///

Patient 55:

ee. On or about January 12, 2008, at 2102 hours, Respondent signed out one (1) 2 mg. vial of Midazolam for administration. Respondent charted the administration of .5 mg. of Midazolam at 2111 hours, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

ff. On or about January 12, 2008, at 2250 hours, Respondent charted the administration of .5 mg. of Midazolam. However, there was no corresponding withdrawal of Midazolam in or about that time frame.

Patient 56:

gg. On or about January 19, 2008, at 1940 hours, Respondent signed out one (1) 2 mg. injectable of Dilaudid for administration. Respondent charted the administration of .4 mg. of Dilaudid at 1954 hours, but failed to account for the remaining 1.6 mg. in any hospital or patient record.

hh. On or about January 20, 2008, at 0229 hours, Respondent charted the administration of .4 mg. of Dilaudid. However, there was no corresponding withdrawal of Dilaudid in or about that time frame.

Patient 57:

ii. On or about January 27, 2008, at 0055 hours, Respondent signed out one (1) 2 mg. injectable of Morphine for administration. Respondent charted the administration of the Morphine at 0117 hours. The administration of the Morphine was inconsistent with physician's orders calling for the administration of that medication every four (4) hours, in that the previous dose was administered at 2341 hours (January 26, 2008).

Patient 58:

jj. On or about July 27, 2008, at 0157 hours, Respondent signed out one (1) 1 mg. bag of Dilaudid for a PCA, but failed to account for the Dilaudid in any hospital or patient record.

///

///

///

Patient 63:

kk. On or about July 4, 2008, at 2151 hours, Respondent signed out one (1) 5 mg. tablet of Oxycodone for administration. Respondent charted the administration of the Oxycodone at 2155 hours. The administration of the Oxycodone was inconsistent with physician's orders calling for the administration of that medication every six (6) hours, in that the previous dose was administered at 1843 hours.

Patient 64:

ll. On or about July 14, 2008, at 0535 hours, Respondent signed out one (1) 2 mg. vial of Midazolam for administration. Respondent charted the administration of 1 mg. of Midazolam at 0709 hours, but failed to account for the remaining 1 mg. in any hospital or patient record.

Patient 65:

mm. On or about July 5, 2008, at 2123 hours, Respondent signed out two (2) tablets of Percocet for administration. Respondent charted the administration of the Percocet at 2134 hours. Respondent charted the patient's pain level at 6. The administration of the Percocet was inconsistent with physician's orders calling for the administration of two tablets for a pain level ranging between 7-10, and one tablet for a pain level ranging between 3-6.

Patient 66:

nn. On or about August 10, 2008, at 2354 hours, Respondent signed out 2 mg. injectable of Morphine, but failed to account for the Morphine in any hospital or patient record.

Patient 67:

oo. On or about August 3, 2008, at 0039 hours, Respondent signed out one (1) tablet of Vicodin for administration. Respondent charted the administration of the Vicodin at 0046 hours. The administration of the Vicodin was inconsistent with physician's orders calling for the administration of that medication every six (6) hours, in that the previous dose was administered at 2126 hours (August 2, 2008).

///

///

///

Patient 68:

pp. On or about June 8, 2008, at 0547 hours, Respondent signed out one (1) tablet of Vicodin for administration. Respondent charted the administration of the Vicodin at 0551 hours. The administration of the Vicodin was inconsistent with physician's orders calling for the administration of that medication every four (4) hours, in that the previous dose was administered at 0317 hours.

Patient 69:

qq. On or about June 8, 2008, at 0703 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl at 0708 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

Patient 72:

rr. On or about March 29, 2008, at 2033 hours, Respondent signed out two (2) tablets of Percocet for administration. Respondent charted the administration of the Percocet at 2035 hours. Respondent charted the patient's pain level at 5. The administration of the Percocet was inconsistent with physician's orders calling for the administration of two tablets for a pain level ranging between 7-10, and one tablet for a pain level ranging between 4-6.

Patient 73:

ss. On or about June 13, 2008, at 2011 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl at 2016 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

Patient 74:

tt. On or about July 11, 2008, at 2123 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl at 2133 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

uu. On or about July 12, 2008, at 0232 hours, Respondent signed out 100 mcg. of Fentanyl for administration. Respondent charted the administration of 25 mcg. of Fentanyl at 0156 hours, but failed to account for the remaining 75 mcg. in any hospital or patient record.

///

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

16. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between February 1, 2007, and August 23, 2008, while a registered nurse in the Surgical Intensive Care Unit at the Department of Veterans Affairs Medical Center, located in Durham, North Carolina, Respondent was incompetent in the following respects:

a. Respondent repeatedly falsified, made grossly incorrect, inconsistent, or unintelligible entries in hospital, patient or other records pertaining to controlled substances, including inconsistent entries relating to the documentation of wasting controlled substances, as more particularly set forth above in paragraph 15.

b. Respondent failed to act as the patients' advocate by failing to give the patients the opportunity to make an informed decision regarding pain medications prior to administering the medications.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 321551, issued to Susan C. Hunter, also known as Susan Coe Pickel;

2. Revoking or suspending Public Health Nurse License Number 31418, issued to Susan C. Hunter, also known as Susan Coe Pickel;

3. Ordering Susan C. Hunter, also known as Susan Coe Pickel, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

///

///

///

///

4. Taking such other and further action as deemed necessary and proper.

DATED: February 28, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
State of California
Complainant

SA2011100613
10811620.doc